Senate Budget & Fiscal Review

Senator Wesley Chesbro, Chair

Subcommittee No. 3
on
Health, Human Services, Labor, & Veterans Affairs

Senator Wesley Chesbro, Chair
Senator Gilbert Cedillo
Senator Tom McClintock
Senator Bruce McPherson
Senator Deborah Ortiz

March 8th , 2004
2:00 PM, or Upon Adjournment of Session
Room 4203

(Diane Van Maren, Consultant)

Item	*Description*
530	**California Health and Human Services Agency** • CA Health Care Quality Improvement and Cost Containment Commission
4260	**Department of Health Services—Selected Public Health Issues** • AIDS Drug Assistance Program (ADAP) • CA Children's Services (CCS) Program • Genetically Handicapped Persons Program
4260	**Department of Health Services—Selected Medi-Cal Issues** • Federal Office of Inspector General Report on Drug Rebates • Enrollment Caps • FQHC Clinics • Medi-Cal Rates—Governor's 10 percent reduction • Processing for Breast and Cervical Cancer Eligibility
4280	**Managed Risk Medical Insurance Board—Selected Issues**

PLEASE NOTE: **Only those items contained in this agenda will be discussed at this hearing. Please see the Senate File for dates and times of subsequent hearings**.

I. 530 California Health & Human Services Agency

A. BACKGROUND

Purpose and Description

The California Health and Human Services Agency (CHHS) administers the state's health, social services, rehabilitative and employment programs. The Secretary of the CHHS advises the Governor on major policy and program matters and oversees the operation of the agency departments. The purview of the CHHS includes: (1) the departments of Aging, Alcohol and Drugs, Community Services and Development, Developmental Services, Health Services, Mental Health, Rehabilitation, and Social Services, (2) the Health and Human Services Data Center, (3) the Office of Statewide Health Planning and Development, (4) the Managed Risk Medical Insurance Board, and (5) the Emergency Medical Services Authority.

Through the Budget Act of 2001 and SB 456 (Speier), Statutes of 2001, the Office of Health Insurance Portability & Accountability Act (HIPAA) Implementation was created. This office resides within the CHHS Agency.

Overall Budget of CHHS Agency

The budget proposes total expenditures of $5.6 million ($3.8 million General Fund), or a *net* increase of $426,000 (General Fund) over the Budget Act of 2003, and 23 positions for the agency. Of this amount, almost $3.5 million and ten positions are for the Office of HIPAA Implementation.

Summary of Expenditures (dollars in thousands)	**2003-04**	**2004-05**	**$ Change**	**% Change**
Secretary for Health & Human Services	$2,208	$2,063	($145)	6.5
Office of HIPAA	$3,635	$3,509	($126)	3.5
Total, CHHS Agency	**$5,843**	**$5,572**	**($271)**	**4.6**

B. ITEM FOR DISCUSSION

1. CA Health Care Quality Improvement and Cost Containment Commission

Background: Chapter 672, Statutes of 2003 (AB 1528, Cohn), established a California Health Care Quality Improvement and Cost Containment Commission (Commission) to be convened by the Governor. The Commission is to be composed of 27 members, 17 of whom shall be appointed by the Governor, four by the Senate Committee on Rules and four by the Speaker of the Assembly.

The purpose of the Commission is to research and recommend appropriate and timely strategies for promoting high quality care and containing health care costs (both public and employer-sponsored). The Commission is directed to issue a report by *January 1, 2005* on these strategies and shall examine specified key areas, including: (1) assessing California's health care needs and available resources; (2) lowering the cost of health care coverage; (3) improving the quality of health care; (4) increasing the transparency of health care costs and the relative efficiency with which care is delivered, and (5) the use of disease management, wellness, prevention, and other innovative programs to keep people healthy while reducing costs and improving health outcomes.

Governor's Proposed Budget: The Governor proposes **an increase of $364,000 (General Fund) and two positions—a Career Executive Assistant III and an Associate Governmental Program Analyst-- to staff the California Health Care Quality Improvement and Cost Containment Commission as contained in AB 1528, Statutes of 2003.**

The two requested positions would be limited term appointments until *June 30, 2005*.

Of the requested total amount, $150,000 (General Fund) is designated for external content experts from the research, university, and foundation community to investigate and analyze the specified key areas noted above, as well as other factors that contribute to the rising cost of health care.

The Administration is also seeking approval of trailer bill legislation to extend by one year the reporting date to the Legislature (i.e., January 1, 2005 to January 1, 2006).

Subcommittee Request and Questions: The Subcommittee has requested the CHHS Agency to respond to the following questions:

- **1.** When may the Commission be constituted and the work commence?
- **2.** Since the Administration is seeking to extend the reporting date to the Legislature by one-year, **does the Administration also want to extend the limited-term appointments for the two staff positions by one year (to June 30, 2006)?**

Subcommittee Staff Recommendation: The results from the research and analysis could be very useful for California and could facilitate the restructuring of health care services provided by both government and business from several vantage points. **Therefore, it is recommended to approve the budget request, including the trailer bill date change, but to utilize a different funding source, other than the depleted General Fund. It is recommended to utilize the**

Managed Care Fund as established in Section 1341.4 of the Health and Safety Code for this purpose, and to place a limit on its use for this activity. As such, the following trailer bill language is recommended:

> **Amend Section 1341.4 as follows:** (a) In order to effectively support the Department of Managed Health Care in the administration of this law, there is hereby established in the State Treasury, the Managed Care Fund. The administration of the Department of Managed Care shall be supported from the Managed Care Fund. **(b) For the 2004-05 and 2005-06 fiscal years only, up to $350,000 from the Managed Care Fund may be used annually to support staff and related functions associated with the California Health Care Quality Improvement and Cost Containment Commission, established by Chapter 672, Statutes of 2003. (c)** In any fiscal year, the Managed Care Fund shall maintain not more than a prudent 5 percent reserve unless otherwise determined by the Department of Finance.

It should be noted that there will be over $1 million in reserve in the Managed Care Fund even after this appropriation is made.

In addition, if the Administration needs to extend the limited-term appointments for the two staff positions by one year (to June 30, 2006), that seems reasonable given the change in the reporting timeframe.

II. 4260 Department of Health Services—Selected Public Health Programs

1. AIDS Drug Assistance Program (ADAP)— (*See Issues "A" to "C" for Discussion)*

Overall Background on the ADAP: ADAP **is a subsidy program for low and moderate income persons (individual income cannot exceed $50,000) with HIV/AIDS who have no health care coverage for prescription drugs and are *not* eligible for the Medi-Cal Program.**

There are about 22,733 clients enrolled in ADAP (as of February 18, 2004).

Under the program eligible individuals receive drug therapies through participating local pharmacies under subcontract with the statewide contractor. The state provides reimbursement for drug therapies listed on the ADAP formulary (**about 151 drugs currently**). **The formulary includes anti-retrovirals, hypolipidemics, anti-depressants, vaccines, analgesics, and oral generic antibiotics.**

ADAP is cost-beneficial to the state. Without ADAP assistance to obtain HIV/AIDS drugs, **infected individuals would be forced to (1)** postpone treatment until disabled and Medi-Cal eligible or **(2)** spend down their assets to qualify for Medi-Cal. **About 50 percent of Medi-Cal costs are borne by the state, as compared to only 30 percent of ADAP costs.**

Since the AIDS virus can quickly mutate in response to a single drug, medical protocol now calls for Highly Active Antiretroviral Treatment (HAART) which minimally includes three different anti-viral drugs. As such, expenditures in ADAP have increased. Under the program, individuals receive drug therapies through participating local pharmacies under subcontract with a statewide contractor. Studies consistently demonstrate that early intervention, minimizes more serious illness, reduces more costly treatments and maximizes an individuals productivity and health.

The DHS notes that ADAP has grown in response to (1) increased demand brought about, in part, by the development of new, more efficacious but costly therapies, (2) increased caseload, and (3) changes in drug utilization as therapies shift due to drug resistance over the course of treatment as individuals live with AIDS.

Budget Act of 2003 and Use of Other General Fund Resources: Through language contained in the Budget Act of 2003, the Administration had flexibility **to utilize up to $7 million (General Fund) in resources from the HIV Therapeutic Monitoring Program** for the ADAP in the event additional expenditure authority was needed for the ADAP during the course of the fiscal year. **The Administration has just recently utilized this funding source.**

As such, the *revised* current-year budget for ADAP is $212.1 million ($64.1 million General Fund, $ 50.3 Drug Rebate Funds, and $97.7 million federal funds).

Governor's Proposed Mid-Year Adjustment and Budget—Capped Enrollment & Reduced Funding: As part of his Mid-Year Reduction package, the Governor proposes **to cap enrollment in ADAP as of January 1, 2004 for proposed savings of $275,000 (General Fund) in 2003-04, and $550,000 (General Fund) in 2004-05 by denying services to about 1,392 people (by June 30, 2005).**

The Governor's 2004-05 budget proposes total expenditures of *only* $207.3 million ($63.8 million General Fund, $97.7 million federal funds and $45.8 million in Drug Rebates) to serve 23,891 clients (Governor's capped enrollment level). As such, the Governor's budget reflects a *decrease* of $4.8 million (a decrease of $300,000 General Fund and $4.5 million in Drug Rebates).

Summary of the Governor's ADAP Budgets:

Funding Source (Rounded)	Governor's 2003-04 Budget	Governor's 2004-05 Budget
General Fund	$64.1 million	$63.8 million
Drug Rebates	$50.3 million	$45.8 million
Federal Funds	$97.7 million	$97.7 million
TOTALS	**$212.1 million**	**$207.3 million**
Difference		***Less* $4.8 million**

(See next page for the specific budget discussion ISSUES—A, B, and C.)

ISSUE "A"—Potential Savings Through Program Efficiencies & Cost Containment

Background--Pharmacy Benefit Manager and Potential Alternatives: In 1997, the DHS contracted with a pharmacy benefit manager (PBM) to centralize the purchase and distribution of drugs under ADAP. **According to the DHS, Ramsell Corporation has successfully completed the third year of a five-year contract with ADAP. Presently there are about 238 ADAP enrollment sites and about 3,309 pharmacies available to clients located throughout the state.**

The DHS is currently working with the University of AIDS Research Program (UARP) and others to gather information and calculate cost data to examine alternative drug purchasing systems, including (1) continuation of the PBM process, (2) using a "prime vendor" system whereby bulk purchasing is used to secure prices (versus using a rebate model), and (3) using a state direct purchase method. More information regarding these options and methods should be forthcoming in summer**. It is anticipated that the state's Request for Proposal for administering ADAP will likely be released in late October 2004 for services to begin July 1, 2005. No substantive changes are anticipated prior to this date.**

Option for Savings—Limit Prescription Refill Frequency: Through discussions with advocacy groups and the DHS, it appears that **some General Fund savings can be achieved through the implementation of certain program efficiencies and cost containment actions.**

ADAP's current policy is 80 percent drug utilization (i.e., on a 30-day prescription, the *earliest* refill is on the 24th day) prior to refilling a prescription. This policy reflects how most Third Party providers refill prescriptions. **However, based on discussions Subcommittee staff has had with the DHS, if the refill policy was changed to a 90 percent drug utilization policy (i.e., refill at the 27th day) a savings of $500,000 (General Fund) could be achieved**.

This savings level assumes that an ADAP client fills an ADAP-funded prescription 7.6 months per year (since clients enter and leave the program every day) and takes into consideration drug accumulation patterns. **The DHS notes that most ADAP pharmacies would likely be willing to comply with this possible change.**

Option for Savings—Use an "Automatic" Refill Interval of 6 Months: An "automatic" refill is the practice of refilling, and in some cases delivering, prescriptions to ADAP clients without requiring any action on the part of the ADAP client or the physician. **Presently, ADAP does not directly limit refills, because the subscribing physician limits the number of refills available without a physician authorization, and the ADAP client must contact the pharmacy to fill the prescription each month.** The DHS notes that automatic refills assist ADAP clients in staying adherent to their antiretroviral regiments but that there is some potential for pharmacy fraud. (It should be noted that the ADAP PBM also conducts monitoring of the pharmacies.)

According to the DHS, current HIV medical practice standards include medical monitoring of viral load levels every three to six months. Further, New York recently adopted a five

month refill limit for their HIV/AIDS drug program. As such, the DHS has been considering a physician refill verification interval.

Based on an initial estimate, it is believed that $300,000 in General Fund savings can be achieved from implementing a six-month interval refill requirement in ADAP.

Subcommittee Staff Recommendation: Program efficiencies and cost containment for ADAP must be balanced against adequate ADAP client access to medications with strict adherence requirements, as well as not cost shifting to other publicly-funded programs (such as local health jurisdictions and Medi-Cal). **The two options presented above—limiting the prescription refill frequency and implementing a six-month interval refill requirement—seem to be reasonable strategies which provide balance and cost containment.**

It is therefore recommended for the Subcommittee to direct the DHS to implement these two actions effective July 1, 2004 and to reduce the ADAP budget by a total of $800,000 (General Fund).

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1. DHS, Can the two proposed modifications for cost containment—establishing a refill policy at the 27th day for drugs, and using a six month refill interval—be incorporated into the ADAP in a workable manner?**
- **2. DHS, From a technical assistance basis, are the proposed savings identified in the agenda reasonable?**

Budget Issue: Does the Subcommittee want to adopt the staff recommendation to reduce by $800,000 (General Fund) as the result of the above outlined program efficiencies?

ISSUE B—Governor's Proposed Cap on ADAP Clients *(See Hand Out)*

Governor's Mid-Year Reduction and Budget Year Proposals: As part of his Mid-Year Reduction proposal (for 2003-04) and proposed budget (2004-05), the Governor seeks **to cap enrollment in various health and human services programs, including the ADAP.**

Under the Governor's proposal, ADAP would be capped in the current-year at 23,891 clients (estimated ADAP enrollment as of January 1, 2004). Once the enrollment cap has been reached, eligible individuals needing services would be placed on a waiting list for services. According to the DOF, the waiting list would be based on a first-come-first served basis. The Governor **assumes savings of $275,000 (General Fund) from this effort in his Mid-Year calculations by denying 696 individuals ADAP drug access. For the budget year, the Governor assumes savings of $550,000 (annualized savings) by denying 1,392 individuals ADAP drug access.**

These proposed savings levels do not take into account *any* administrative cost off-sets or *any* additional costs that may be incurred under the Medi-Cal Program if individuals shift from this program over to Medi-Cal in order to obtain services.

Subcommittee Staff Comment: **Without ADAP** assistance to obtain HIV/AIDS drugs, **individuals would be forced to: (1)** postpone treatment until disabled and Medi-Cal eligible, or **(2)** spend down their assets to qualify, increasing expenditures under Medi-Cal. **According to the DHS, 50 percent of Medi-Cal costs are borne by the state, whereas only 30 percent of ADAP costs are borne by the state.** As such, ADAP has been a cost-beneficial program for the state.

In addition the proposal would require increased expenditures for the administration of a waiting list, including personnel, computer system changes and related administrative functions. ADAP also affects demand for Medi-Cal services. No comprehensive cost estimate has been forthcoming from the DOF on either of these aspects.

Legislative Analyst's Office Recommendation--Reject: In her Analysis, **the Legislative Analyst recommends to reject the Governor's proposed caseload cap in the ADAP because it is highly probable that any short-term savings would be offset by increased future costs for treatment services.**

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** DHS, **briefly explain** how the Governor's proposed enrollment cap would operate.
- **2. What costs would be incurred to administer such a cap?**
- **3. What costs would be potentially incurred if individuals not receiving ADAP services would become sicker and need to transfer to the Medi-Cal Program (based on disability)?**

Budget Issue: Does the Subcommittee want to adopt or reject the Governor's proposal to capitate the number of low-income individuals with HIV/AIDS who do not have medical coverage for AIDS drugs at the January 1, 2004 level?

ISSUE "C"—ADAP Drug Rebates—Their Estimating, Collecting, Tracking & Expenditure

Background—Overview of Rebate Process (Federal and State Supplemental): Prior to 1997-98, drug rebate collection under the ADAP was voluntary and almost all pharmaceutical manufacturers chose *not* to participate. However this has subsequently changed.

Both federal and state law require ADAP drug rebates to be paid in accordance with the same formula by which state Medicaid (Medi-Cal) programs are paid rebates. This formula is established by the federal Center for Medicare and Medicaid (CMS). **Due to federal restrictions regarding the rebate calculation formula, the actual calculation (i.e., the specific multiplier) is not available to the state or the public.** ***Therefore, the actual rebates that California actual receives varies by the amount invoiced to the pharmaceutical manufacturer.***

In addition, California also negotiates additional "supplemental" rebates under ADAP via a special taskforce, along with eight other states (representing the largest ADAP's in the country). The mission of this taskforce is to secure additional rebates from eight manufacturers of antiretroviral drugs (i.e., most expensive and essential treatment therapies). It is estimated at this time that California will obtain up to $5 million in supplemental rebates from this effort. (These agreements vary by manufacturer and may change annually or upon renewal of manufacturer agreements.)

It should also be noted that rebates have grown as more drugs have been added to the ADAP formulary. In 1997-98, there were 54 drugs on the formulary. Today there are 151 drugs.

Background—How DHS Processes Rebates: ADAP uses a database invoice and payment tracking system, by manufacturer and billing quarter, for both the regular and "supplemental" rebate programs. Manufacturers are billed about 60-days after the end of a quarter based on the number of units purchased through ADAP. **All rebates received from the manufacturers are entered into the ADAP database, and then deposited into an "uncleared collection" account. This "uncleared collection" account is a catch-all account used for a variety of checks that the DHS receives, not just for ADAP rebates.**

The ADAP rebates cannot be used for program expenditures until they pass from the "uncleared collection" account, and become a reimbursement. Further, budget authority is then required to expend the reimbursement. ***It should be noted that there is currently no mechanism to assure that ADAP rebate dollars are dedicated solely for the purposes of the program, although federal policy requires rebates to be used for drug purchases.***

Background—"Accumulated" ADAP Rebates Available: As noted in the table below, **the ADAP has collected more rebate each year than the program has had budget authority to actually spend. (Remembering that (1)** rebates have grown as more drugs have been added to the ADAP formulary, **(2)** rebate agreements vary by manufacturer and may change annually or upon renewal of manufacturer agreements,**(3)** rebate amounts vary by the amount invoiced to the manufacturer and the price of the drug product, and **(4)** rebate amounts vary contingent upon the actual rebate amount the state can collect**)**.

As such, the "accumulated" rebate (i.e., from 1997-98 through 2002-03) became "one-time" rebate funds used to address ADAP shortfalls and to backfill for General Fund support in the program. ***The current "accumulated" rebate amount that is presently not obligated for expenditure (i.e., not accounted for in the Governor's budget) is $21 million.***

Table: Summary of "Accumulated" Drug Rebates

Fiscal Year	Total Rebate Collected	Rebate Budget Authority	Rebate Dollars Used to Off-Set General Fund	Accumulated Rebate Amount (Not Obligated)
On going			$460,000 (state staff)	
1997-98	$10,085,779	$7,829,000		
1998-99	14,287,056	11,429,000		
1999-2000	19,217,487	13,129,000		
2000-01	24,138,051	14,039,000		
2001-02	30,930,504	19,200,000		
2002-03	41,290,230	26,176,850		
SUBTOTAL (1997 to 2002)	**$140,003,109**	**$91,812,850**		**$48,190,259**
2003-04*	Billed not received	50,342,000	21,374,000	-21,374,000
2004-05*	N/A	45,822,000	5,822,000	-5,822,000
TOTALS (Rounded)	**N/A**	**N/A**	**$27,196,000 (plus the staff)**	**$20,994,000 (Net amount)**

* Proposed in Governor's Budget

Subcommittee Staff Comments and Recommendation: As noted in the discussion above, the estimating, collecting, tracking and expenditure of **drug rebates is complex, with some aspects of the process being more manageable and predictable than others**. **The Office of AIDS has done a commendable job in assertively seeking manufacturer rebates, particularly in more recent years. These efforts have enabled the program to (1)** continue to provide access to drugs for individuals in need, **and (2)** defer additional General Fund expenditures, or in more recent years, directly offset the use of limited General Fund resources. **This said however, modifications are needed.**

Subcommittee Staff Comments and Recommendation* (continued): First, it is recommended to establish a special deposit fund for ADAP Drug Rebates through *placeholder* trailer bill legislation**. **A special fund for this purpose will assist in facilitating both administrative and manufacturer accountability through the publication of a Fund Condition Statement in the annual budget, as well as through standardized accounting procedures.** ***In addition, a special fund can earn interest.

Due to concerns regarding the variability of drug prices and rebate collections, it is suggested to consider having the special fund be **continuously appropriated** so that rebate funds can be utilized (once collected) in a responsive manner.

Second, in order to more fully fund the ADAP, it is recommended to appropriate the $21 million (in accumulated ADAP Drug Rebate Funds) for ADAP in the budget year and to use a portion of this amount to backfill for General Fund support. Subcommittee staff has been informed that to more fully fund the ADAP in the budget year, additional resources are needed. These resources are needed to mitigate the potential for drugs being eliminated from the formulary or other measures that could endanger an individual's health status.

Given the state's fiscal crisis and the availability of limited resources, the situation necessitates a balance to provide access to drugs, contain program costs, offset General Fund resources, secure more drug rebates, and secure more federal funds from the Bush Administration.

In addition, it will be important for the Legislature, Administration, and advocates to work collaboratively in reviewing the work currently being conducted by the University of AIDS Research Program (UARP) regarding their examination of alternative drug purchasing systems. This work includes examination of (1) continuation of the PBM process, (2) using a "prime vendor" system whereby bulk purchasing is used to secure prices (versus using a rebate model), and (3) using a state direct purchase method. **As noted earlier, more information regarding these options and methods should be forthcoming in summer** for development of a new Request for Proposal process to administer the ADAP in 2005-06**.**

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** DHS, Please **briefly explain** the $21 million in available "accumulated" rebate funds.
- **2.** DHS, **From a technical assistance perspective, is it likely that additional funds above the Governor's budget of $207.3 million may be needed to more appropriately fund the ADAP in 2004-05?**

Budget Issue: Does the **Subcommittee want to adopt the Subcommittee staff recommendation, or craft other options?**

2. Genetically Handicapped Persons Program (GHPP)—*ISSUES "A" to "C"*

Overall Background: The GHPP **provides diagnostic evaluations, treatment services, and medical case management services for adults with certain genetic diseases**, including cystic fibrosis, hemophilia, sickle cell disease, Huntington's disease, and certain neurological metabolic diseases. **The services covered by the GHPP include all the medically necessary medical and dental services needed by the client, not just the services related to the GHPP-eligible condition. (GHPP differs from the California Children's Services (CCS) Program in that CCS covers only services related to the CCS eligible condition.)**

GHPP is suppose to be the "payer of last resort" (as a 100 percent General Fund program) meaning that third-party health insurance and Medi-Cal coverage are to be used first. GHPP authorized services are **reimbursed according to the following guidelines** established by the DHS:

- **For GHPP-only clients** (non-Medi-Cal eligible) **with no health insurance**, GHPP reimburses providers using **solely General Fund support at Medi-Cal fee-for-service rates with claims adjudicated through EDS (state's fiscal intermediary);**
- GHPP clients with health insurance are required to use their health insurance first before GHPP state support is used. **Providers are to bill third-party health insurance first for these clients;**
- **Medi-Cal clients enrolled in GHPP may be enrolled in Medi-Cal Managed Care plans *or* be in fee-for-service Medi-Cal and are provided assistance as follows:**
    - **Managed care Medi-Cal clients** are only eligible for GHPP special care center team assessment and evaluation services which are reimbursed fee-for-services. All other benefits are covered by the health plans under the managed care arrangement.
    - Fee-for-service Medi-Cal clients have services paid by Medi-Cal but are case managed by GHPP.

Governor's Proposed Budget Overall: The budget proposes total **expenditures of $49.5 million ($49.3 million General Fund and $200,000 Enrollment Fees) in the GHPP to support a patient caseload of 1,682 individuals (837 Medi-Cal eligible and 845 GHPP-only).**

The Governor proposes to make three significant changes to the GHPP Program. Each of these will be discussed further below, but include the following items:

- **Cap enrollment for GHPP-only patients** (i.e., not Medi-Cal eligible) for proposed savings of $194,000 (General Fund) by not providing services to 36 medically needy individuals in 2004-05.
- **Implement a 10 percent rate reduction, in addition to the five percent reduction adopted in the Budget Act of 2003**, for proposed savings of $6.5 million (General Fund).
- **Implement a new copayment for the program effective July 1, 2004** for savings of $576,000 (General Fund). **A $10 copayment would be charged for each service**.

DHS Notes Substantial Cost Increases Over Past Years: **Expenditures for the GHPP have been rapidly increasing over several years.** In fact, the program **increased well over 320 percent from 1996 to 2001** (from $12 million General Fund to $38.8 million General Fund).

ISSUE "A"—Blood Factor Rebates—(1) State Owed Reimbursement on Rebates, and (2) State Needs to Proceed with Contract Savings & Related Expenditure Reduction Measures

Background—State's Authority to Collect Rebates: The Omnibus health trailer bill to implement the Budget Act of 2002 **authorized the GHPP to receive rebates on anti-hemophilia Blood Factor**. This authority was extended in the Omnibus health trailer bill to implement the Budget Act of 2003 (Chapter 230, Statutes of 2003) to give the DHS authority to contract for drug rebates for GHPP and the California Children's Services (CCS) Program. **Additionally, the GHPP received qualification as a "State Pharmaceutical Assistance Program" from the federal Centers for Medicare and Medical Services (CMS).**

Background—Hemophilia: Generally, hemophilia refers to a group of bleeding disorders, most commonly "factor 8" and "factor 9" deficiencies but also include von Willebrands Disease and other "factors". Patients with these disorders are classified based on their level of procoagulant that is deficient. Individuals with these disorders require treatment with factor concentrates for bleeding episodes. These factor concentrates are medications that are either made through purification of plasma proteins or through a process of genetic engineering. These products are clinically complex and cannot be easily considered interchangeable.

Background—Rebates Owed to the State from 2002-03 Fiscal Year: According to information obtained from the DHS, all but two pharmaceutical manufacturers have substantive rebate balances owed to the state. **Only $153,000 has been collected from an amount owed of $4.2 million for the 2002-03 fiscal year.** The DHS notes the following amounts are owed:

Manufacturer	Total Due	Balanced Owed From *2002-03*
Alpha Therapeutic	$155,818	*Paid*
American Red Cross	168,948	$168,948
Aventis	220,319	220,319
Baxter	2,541,361	2,541,361
Bayer	263,698	263,698
Genetics Institute	382,447	382,447
Nabi	4,174	*Paid*
Novo Nordisk	494,507	494,507
TOTAL (Rounded)	**$4,231,000**	**$4,078,000**

According to the DHS, discussions are underway with manufacturers who have not paid the rebates. Letter were mailed to manufacturers last December and January. **However, *no firm date* as to when resolution can be expected and reimbursement to the state made, has as yet been identified.**

Background—Contract & Rebate Savings for 2003-04 Are Lost, and 2004-05 is Low:
Through the Budget Act of 2003, the Administration and Legislature assumed that **$7.5 million in General Fund savings could be achieved within the GHPP through drug rebate collection and through the implementation of other contract savings, such as medical supplies and durable medical equipment**. This savings figure was based on a survey conducted by the DHS Audits and Investigations Division.

The DHS was provided three new state positions, from a **request of five positions, to contract for rebates for blood factor products as well as other items for both the GHPP as well as the California Children's Services (CCS) Program.** Though some resources were provided, **the DHS states that none of the original $7.5 million in General Fund savings can be achieved in 2003-04 (current year), as reflected in the Governor's revised current year budget.**

In addition, the Governor's budget for 2004-05 reflects a savings of only $1.5 million (General Fund) for the same contracting and rebate functions as identified in last year's budget as savings of $7.5 million.

The DHS contends that their experience in collecting the GHPP blood factor rebates for 2002-03 (as discussed above) has demonstrated that the process of collecting rebates is staff intensive, requires multiple steps to collect funds, and ongoing changes in manufacturers' intent and process. **The DHS notes they are in the process of developing a standard contract for the GHPP effort but that the workload is difficult and higher priorities—such as authorizing services to GHPP clients—often take precedence**. Further they state that since the position requested in last year's budget for the Children's Medical Services Branch that administers GHPP was not authorized, the program does not have resources to undertake the workload.

Further, DHS contends that since the two additional positions requested in last year's budget for the GHPP program branch were not approved by the Legislature, additional work could therefore not be done (i.e., positions could not be redirected according to the DHS).

Background—Other Expenditure Reductions for 2003-04 Are Lost, and 2004-05 is Zero:
Through the Budget Act of 2003, the Administration and Legislature assumed that **$1 million in General Fund savings would be achieved through the following actions:**

- **(1) Implement utilization controls on anti-hemophilia factor;**
- **(2) Assure that other health care coverage is utilized before the General Fund is used for service reimbursement; and**
- **(3) implement a more efficient system for assessment and collection of GHPP client fees.**

The Legislature provided three new state positions for this purpose, as requested by the DHS. However, due to hiring freezes imposed by the DOF, it has taken longer for the positions to be filled and for savings to commence. One position remains frozen as the DHS has not received a freeze exemption. The DHS states that it will take six to 12 months after the positions are filled for savings to begin.

Governor's Proposed Budget: The **Governor's proposed budget for 2004-05 assumes the following with respect to these issues:**

- ***Collection of 2002-03 Rebates Owed to State:*** No dollars assumed.
- ***Contract Savings for Pharmaceuticals, Medical Supplies, et al:*** $1.5 million in savings (which is **$6 million *less*** than stated in the 2003-04 budget assumptions).
- ***Expenditure Reductions for Core Program Functions:*** No dollars assumed.

Subcommittee Staff Comment and Recommendation: The issues identified above—**collecting owed rebates for Blood Factor products, obtaining contract savings for medical supplies and related products, and ensuring program efficiencies—are *core functions* to the overall operation of the GHPP. These types of program efficiencies should be implemented prior to anyone not being enrolled and receiving services.**

The Legislature provided six positions from an original request of eight positions for this work to be completed. In an era of limited resources, priorities need to be established and economies of scale (such as using contracts were applicable) need to be used. It is clearly evident that the Administration needs to follow through on all of these identified items. **In addition, those manufacturers who owe the state rebates need to come forth immediately to remedy the identified outstanding balances.**

It is therefore recommended for the Subcommittee to take action on the following items for the budget year:

- **(1) Establish a special fund through trailer bill legislation** for the collection of GHPP rebates, as well as rebates received under the California Children Services (CCS) Program (to be discussed below). A special fund will assist in facilitating both administrative and manufacturer accountability through the publication of Fund Condition Statements in the annual budget, as well as through standardizing accounting procedures. **In addition, a special fund can earn interest.**
- **(2) Appropriate the $4.1 million** in identified, but as yet not fully uncollected, rebates from 2002 for the GHPP. (As noted in the above chart, about $153,000 of these funds have indeed been collected.) **Of this amount, utilize $89,000 (rebate funds) for a new Associate Governmental Program Analyst (AGPA) position to assist with the various functions identified above (as similarly done under the ADAP Program). The remaining amount—about $4 million—shall be used as a General Fund offset (i.e., serves as a fund shift and saves General Fund).**
- **(3) Recognize increased savings of $5 million (General Fund)** for contracts, pharmaceutical rebates, medical supplies and related items, **above the Administration's proposed savings of only $1.5 million (General Fund).** The original figure in the Budget Act of 2003 was $7.5 million for these items. The uncollected blood factor rebates from 2002 are alone $4.1 million. **As such, the DHS should be able to obtain more blood factor rebates, as well as savings from other drugs used in the program, and from medical supplies and durable medical equipment.**
- **(4) Recognize savings of $1 million (General Fund)** by implementing the core program improvements as assumed in the Budget Act of 2003. The AGPA position should be able to provide assistance when hired. Until this time, it seems reasonable to assume that some existing staff or redirected staff could be used in this effort.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1. Please describe the DHS efforts to collect the Blood Factor rebates owed to the state from 2002. What kind of response has the DHS received from the various manufacturers?**
- **2.** Can additional savings be generated from collecting rebates, and contracting for various supplies as discussed above?

Budget Issue: Does the Subcommittee want to adopt the Subcommittee staff recommendations or craft other options**?**

ISSUE "B"—Governor's Proposed GHPP Reductions—(1) Cap on Program, (2) Implement Copay, and (3) Reduce Rates by Another 10 Percent

Governor's Proposed Budget Overall: The budget proposes total **expenditures of $49.5 million ($49.3 million General Fund and $200,000 Enrollment Fees) in the GHPP to support a patient caseload of 1,682 individuals (837 Medi-Cal eligible and 845 GHPP-only).**

The Governor proposes to make three significant changes to the GHPP Program, as noted below:

- **Cap enrollment for GHPP-only patients as of January 1, 2004;**
- **Implement a 10 percent rate reduction, in addition to the five percent reduction adopted in the Budget Act of 2003**; and
- **Implement a new copayment for the program effective July 1, 2004.**

Background on Governor's Enrollment Cap: As part of his Mid-Year Reduction package, the Governor proposes **to cap enrollment in the GHPP as of January 1, 2004 for proposed savings of $245,000 (General Fund) in 2003-04 and $194,000 (General Fund) in 2004-05 by denying services to about 842 people (average monthly wait list of 3 people). The proposed cap would affect GHPP-only individuals (i.e., not eligible for Medi-Cal).**

No information has been provided by the Administration as to what administrative costs would be incurred. **The "waiting list" would not be done on a medical necessity basis and would likely result in people suffering severe harm or even death given the medical intensity of individuals receiving services under the program.**

The Legislative Analyst in her Analysis recommends to reject the Governor's enrollment cap for the GHPP because the minor savings achieved from the action would not be worth the increased administrative costs and operational problems.

Background on 5 Percent Reduction and Governor's Proposed 10 Percent Rate Reduction:
The Governor proposes to implement an additional 10 percent rate reduction, which is in addition to the five percent reduction adopted in the Budget Act of 2003. **Proposed savings of $4.3 million (General Fund) are assumed from the 10 percent rate reduction, and $2.2 million (General Fund) is assumed from the five percent reduction (for a total of $6.5 million General Fund in all)**.

Although **a court injunction** is in place which has halted implementation of the five percent reduction for Fee-For-Service Medi-Cal, it **did not apply to state funded programs.** Therefore, **the DHS is proceeded with reducing by 5 percent the rates paid for non-Medi-Cal services, such as for GHPP-only cases in January.**

Background on Governor's Proposed Copayment: The Governor proposes to implement a new copayment for the program effective July 1, 2004. **A $10 copayment would be charged for each service. Savings of $576,000 (General Fund) are assumed from this action.** The copayment amounts would be in addition to the GHPP enrollment fees which are already required on an annual basis.

The DHS states that the $576,000 (General Fund) savings figure from the copayment proposal assumes that 800 individuals (i.e., the GHPP-only patients) receive on average six services a month at a copay level of $10 per service (i.e., 800 persons x 6 services a month x $10 copay x 12 months). **However, it should be noted that this figure is merely a "placeholder" number.**

The DHS has respectfully acknowledged that more analysis needs to be done on this proposal. **For example, it is unknown what a typical individual would need to pay on a monthly basis.** It is unknown what the average units of service provided are under the GHPP (such as for an individual with hemophilia) and whether all services should have the same level of copayment (e.g., does it make sense to change a $10 copay for blood factor, physician visit, and hospital visits). No monthly or annual threshold limits have been articulated, nor has a potential exemption process for hardship situations.

Subcommittee staff believes that a copay for the GHPP makes sense but that the Administration's proposal **needs additional work, and could benefit from discussions with program participants, providers and applicable advocacy groups. As such, it is recommended to hold this item open, pending further analysis.**

Subcommittee Request and Questions: The Subcommittee has requested for the DHS to respond to the following questions:

- **1. Please articulate how the state would implement and operate the GHPP cap. What administrative costs are associated with this?**
- **2. Please clarify how the existing 5 percent rate reduction is being implemented.**
- **3. Please describe the Administration's proposed additional 10 percent rate reduction. What are the potential affects of this reduction?**
- **4. Please describe the Administration's copayment proposal, including how it would operate.**

3. California Children's Services (CCS) Program—*ISSUES "A" to "B"*

Overall Background: The California Children's Services (CCS) Program provides medical diagnosis, case management, treatment and therapy to financially **eligible children with specific medical conditions, including birth defects, chronic illness, genetic diseases and injuries due to accidents or violence**. **The CCS services must be deemed to be *"medically necessary"* in order for them to be provided.**

The CCS is the oldest managed health care program in the state and the only one focused specifically on children with special health care needs. It depends on a network of specialty physicians, therapists and hospitals to provide this medical care. By law, CCS services are provided as a separate and distinct medical treatment (i.e., carved-out service).

CCS enrollment consists of children enrolled as: (1) CCS-only (not eligible for Medi-Cal or the Healthy Families Program), **(2)** CCS and Medi-Cal eligible, and **(3)** CCS and Healthy Families eligible. **Where applicable, the state draws down a federal funding match and off-sets this match against state funds as well as county funds.**

Background--Governor's Proposed Budget Overall: Total program **expenditures of $220.5 million ($82.5 million General Fund, $75.3 million County Realignment Funds**, **$51.1 million federal Title XXI funds,** $11.1 million federal Maternal & Child Health block grant funds, $500,000 patient enrollment fees, and $2.8 million other funds) are proposed for 2004-05. CCS was included in the State-Local Realignment of 1991 and 1992. As such, counties utilize a portion of their County Realignment Funds for this program.

The Governor proposes the following key changes for the CCS Program:

- **Cap enrollment for CCS-only patients as of January 1, 2004;** and
- **Implement a 10 percent rate reduction, in addition to the five percent reduction adopted in the Budget Act of 2003.**

These issues are discussed below, along with program efficiencies.

ISSUE "A" Contract and Rebate Savings

Background—Contract and Rebate Savings for 2003-04 Are Lost, and 2004-05 is Zero : Through the Budget Act of 2003, the Administration and Legislature assumed that **$2.5 million in General Fund savings could be achieved within the CCS Program through drug rebate collection and through the implementation of other contract savings, such as medical supplies and durable medical equipment**. This savings figure was based on the fact that the CCS Program provides over $130 million in direct services annually and that 30 percent of these services are for such items as medical supplies, durable medical equipment and blood factor product.

The DHS was provided three new state positions, from a **request of five positions, to contract for rebates for blood factor products as well as other items for both the CCS as well as the GHPP (as previously discussed under the GHPP).** Though some resources were provided, **the DHS states that no savings at *all* can be achieved in 2003-04 (current year), as reflected in the Governor's revised current year budget. DHS states that this is because freeze exemptions from the DOF have not yet been received to hire the positions.**

In addition, the Governor's budget for 2004-05 reflects absolutely no savings for the same contracting functions.

Subcommittee Staff Comment and Recommendation: The issues identified above—obtaining **rebates for various drug products, and contract savings for medical supplies and related products—are *core* program *functions.* These types of program efficiencies should be implemented prior to anyone not being enrolled and receiving services.**

It is therefore recommended for the Subcommittee to take action on the following items for the budget year:

- **1. Utilize the special fund** referenced under the GHPP item **for the CCS Program rebates** as well. The DHS fiscal personnel note that one fund for both programs would suffice.
- **2. Recognize savings of $2.5 million** (General Fund) by proceeding with obtaining rebates for various drug products and contract savings as referenced above. Significant economies of scale should be achievable for these products, similarly as they were under the Medi-Cal Program. The AGPA position provided under the GHPP above, as well as existing CCS positions, can be used for this purpose.

Subcommittee Request and Questions: The Subcommittee has requested for the DHS to respond to the following questions:

- **1. Why are no savings being attributed in the current or budget year to obtaining pharmaceutical rebates, or contract savings (such as for medical supplies or durable medical items)?**

ISSUE "B"—Governor's Proposed Reductions—(1) Cap on Program, and (2) Reduce Rates by Another 10 Percent

Governor's Proposed Budget and Proposed Reductions: Total program **expenditures of $220.5 million ($82.5 million General Fund,** $75.3 million County Realignment Funds, $51.1 million federal Title XXI funds, $11.1 million federal Maternal & Child Health block grant funds, $500,000 patient enrollment fees, and $2.8 million other funds) **are proposed for 2004-05. This proposed funding level assumes an enrollment cap and reduced reimbursement rates as discussed below.**

Background on Governor's Enrollment Cap and Subcommittee Staff Comment: As part of his Mid-Year Reduction package, the Governor proposes **to cap enrollment at 37,594 children for CCS-only eligibles as of January 1, 2004. This requires statutory change. His budget proposes savings of $242,000 ($121,000 General Fund) by denying services to 153 children in the current year.**

For the budget year, the Governor assumes a savings of $3.8 million ($1.9 million General Fund and $1.9 million County Realignment Funds) by denying services to 1,256 children in 2004-05.

The Administration has provided no comprehensive cost analysis as to what resources would be needed to implement a cap, or how it would fully operate. Eligibility processing for the CCS is still not fully computerized and the development of a "waiting list" would require re-programming and would be a costly administrative burden. Since CCS is a "realigned" program (shared with the counties) additional complexities would likely be encountered.

Some of these children may be able to obtain treatment through county indigent health care programs or charitable care. **However, CCS children by definition of being enrolled in the program are very medically involved and often require intensive treatment, as well as on-going treatment through their adolescent years.** Capping this program could be catastrophic for these families and their children.

In her Analysis, the Legislative Analyst notes that a cap on CCS enrollment would create an inequitable situation in which children with the most intensive medical needs would lack coverage, while children needing more routine care would have some coverage. **The LAO recommends for the Legislature to reject this cap proposal.**

Background on Governor's Proposed 10 Percent Rate Reduction: The Governor proposes to implement a 10 percent rate reduction, which is in addition to the five percent reduction adopted in the Budget Act of 2003. **Proposed savings of $3.6 million ($1.8 million General Fund) are assumed from the 10 percent rate reduction, and $1.8 million ($905,000 General Fund) is assumed from the five percent reduction (for a total of $2.7 million General Fund in all)**.

Though a court injunction is in place which has halted implementation of the five percent reduction for Fee-For-Service Medi-Cal, **the DHS is proceeding with reducing by 5 percent the rates paid for non-Medi-Cal services, such as for CCS-only cases.**

Through the Budget Act of 2000, the CCS Program was provided a rate increase of 39 percent. Other than a five percent increase granted in 1999, no rate adjustment had been provided since 1982. These rate adjustments resulted from data obtained from the Senate Office of Research and their comprehensive report on the program (published in 2000), plus rate analyses conducted by the DHS, as well as the American Academy of Pediatrics and specialty physician groups.

Subcommittee Staff Comment: **In lieu of the additional 10 percent rate adjustment, the Legislature may want to consider other cost saving options such as** utilization controls on Medical Therapy services, utilization controls on certain pharmaceuticals, medical supplies and laboratory services or other related program efficiencies. **It is suggested to direct Subcommittee staff, the DHS, county representatives and constituency groups to meet to further discuss potential options for future consideration by the Subcommittee.**

Subcommittee Request and Questions: The Subcommittee has requested for the DHS to briefly respond to the following questions:

- **1. Please articulate how the state would implement and operate the GHPP cap. What administrative costs are associated with this?**
- **2. Please clarify how the existing 5 percent rate reduction is being implemented.**
- **3. Please describe the Administration's proposed additional 10 percent rate reduction. What are the potential affects of this reduction?**

III. 4260 Department of Health Services—Medi-Cal Program *(Selected Items)*

A more comprehensive discussion regarding the Medi-Cal Program will be convened by the Subcommittee in April in order to accommodate the Administration and facilitate their discussions regarding potential Medi-Cal changes and reforms.

1. Medi-Cal Drug Rebates & the Collection of Owed Rebates—Why Can't More Be Collected?

Background—Summary of the Medi-Cal Drug Rebate Program: The Medi-Cal fee-for-service Drug Program controls costs through **two major components—(1) a Medi-Cal List of Contract Drugs (or formulary), and (2) contracts with about 100 pharmaceutical manufacturers for supplemental rebates**. Drugs listed on the formulary are available without prior authorization. **In turn, the manufacturers agree to provide certain rebates mandated by both the federal and state government.** The state supplemental drug rebates are negotiated by the DHS with manufacturers to provide additional drug rebates above the federal rebate levels.

According to the DHS, the Medi-Cal fee-for-service program will pay retail pharmacies about $4.4 billion (total funds) in payments in 2004-05 for prescription drugs and medical supplies. The Drug Program collects rebates from these products, as well as from County Organized Health Care Systems for their Medi-Cal items and the Family PACT Program. ***Collectively it is anticipated that rebate collections will total about $1.4 billion (total funds) in 2004-05.***

As required by federal law, rebates are billed quarterly to drug manufacturers on a "per claim" basis. **The DHS bills for over 50 million claims a year.** A drug manufacturer may dispute any claim and that dispute must be resolved between the DHS and the drug manufacturer.

In 2002, the DHS implemented the Rebate Accounting and Information System (RAIS). Using the RAIS, the DHS can now automatically bill and track the collection of state and federal rebates due from manufacturers. Prior to this implementation, the DHS used an antiquated computer system which needed significant human intervention to resolve rebate claims.

Background—Collection of Owed Rebates and Summary of Recent Legislative Actions: **The collection of manufacturer rebate moneys owed to the state has been a long standing issue with the DHS. In a 1996 report**, the Bureau of State Audits (BSA) identified about $40 million in past, owed rebates to the state. **In the BSA April 2003 report, the "aged rebates" owed to the state had escalated to be $216 million (total funds as of September 2001).**

Recent Legislative Actions: **In response to these BSA reports, the Legislature took the following recent actions:**

- ***Budget Act of 2001:*** Provided increased resources to implement the RAIS rebate tracking.
- ***Budget Act of 2002:*** Provided **four new staff** to assist in processing aged rebates and enacted trailer bill legislation to prevent the loss of state drug rebates if manufacturers re-calculate downward their prices. (This was done because manufacturers were retroactively making changes and therefore, reducing rebates.
- ***Budget Act of 2003:*** Provided eleven new staff to assist in processing aged rebates.

Federal Inspector General's Report and DHS Clarification: The federal Officer of Inspector General (OIG) conducted an audit of California's Medicaid (Medi-Cal) Drug Rebate Program which was released in January 2004. **Among other things, the report concluded that the state's program had an *unresolved drug rebate balance of $1.3 billion* (total funds) as of June 30, 2002.**

The DHS objected to this reported OIG balance indicating that the report was in error, and provided the OIG with a revised figure of $818 million (total funds as of June 30, 2002). The DHS sited several federal CMS inaccuracies regarding bad data that were used in the OIG analysis, and gave examples of errors that can cause a drug manufacturer to dispute a drug rebate billing. **The DHS states that since this time, the amount of unresolved/outstanding rebates has *been reduced to about $302.3 million (total funds as of June 2002)* due to payments by drug manufacturers, as shown in the chart below (DHS provided information):**

Table: DHS Summary of Unresolved/Uncollected Rebates

Rebate Year	Adjusted Invoice Total (Total Funds)	Paid Principal (Total Funds)	Outstanding Principal (Total Funds)	Percentage Outstanding
1991	$ 97,900,858	$ 87,373,776	$ 10,527,082	11%
1992	167,744,003	158,367,043	9,376,960	6
1993	194,392,409	186,551,266	7,841,143	4
1994	238,547,577	222,572,042	15,975,535	7
1995	277,248,581	258,967,817	18,280,764	7
1996	315,327,696	304,036,120	11,291,575	4
1997	351,427,087	332,728,549	18,698,537	5
1998	472,001,499	448,490,996	23,510,502	5
1999	625,017,617	584,595,599	40,422,018	6
2000	789,752,321	729,581,742	60,170,578	8
2001	974,008,351	916,739,533	57,268,817	6
2002	585,127,372	556,142,364	28,985,008	5
TOTALS (Rounded)	**$5,088,495,000**	**$4,786,146,000**	**$302,348,523**	**6**

The DHS notes that the $302.3 million (to June 30, 2002) as shown above is similar to the audit findings of the Bureau of State Audits report from April 2003 (as referenced above).

The DHS also contends that a significant portion of the $302.3 million balance represents rebates that have been billed but for a variety of reasons may not be collectable.

Governor's Proposed Budget: The Governor's budget **proposes to collect a total of *only $29.5 million ($14.750 million General Fund)* of the identified $302.3 million** as shown in the chart above. **Of the $29.5 million ($14.750 million General Fund)** in the budget, $5.9 million is identified for 2003-04 and $23.6 million is for 2004-05.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1. DHS, please briefly explain what the $302.3 million (total funds) represents, as well as the $29.5 million (total funds).**
- **2. What specifically is being done to rectify the unresolved claims and when will the backlog in unresolved claims be completely processed?**
- **3. What specifically is being done in response to establishing more internal controls as referenced by the federal OIG?**
- **4. Do you have any recommendations on how to make the billing, collection, and tracking of rebates easier and more efficient?**

Budget Issue: Does the Subcommittee **want to approve or modify the Governor's proposed budget for the collection of aged drug rebates?**

2. Governor's Proposed Enrollment Caps Within the Medi-Cal Program *(See Hand Out)*

Background—Overall: California operates several programs within Medi-Cal whereby specified eligible individuals receive certain critical services. **These critical services include prenatal care, long-term care, and breast and cervical cancer treatment (up to 18 months of treatment only).** Each of these programs are operated on a "state-only" basis (i.e., using state General Fund only, without any federal match).

In addition, California provides full scope **Medi-Cal services to lawfully present (i.e., legal) immigrants** who lost eligibility for certain federal benefits such as Medicaid as a result of the 1996 federal Welfare Reform Law. **Under federal law, persons denied full-scope Medi-Cal based on their immigration status must have access to emergency Medi-Cal services.**

In preserving these services, the state recognized the potential public health consequences of denying preventive and critical health care to very low-income individuals. Studies consistently demonstrate that early intervention minimizes more serious illness, reduces more costly treatments and maximizes an individuals productivity and health. **If these services are not available it is very likely individuals will seek assistance through emergency rooms (via charity care or county payment), or county indigent health care programs.**

Governor's Proposed Mid-Year Reduction and Budget: The Governor proposes to cap enrollment, effective January 1, 2004, in several Medi-Cal programs. **The proposal requires statutory change before implementation can occur.** Presently, no action has been taken on this issue, though other Mid-Year Reductions (i.e., changes to the 2003-04 current year budget) have occurred.

The Governor's proposed budget for 2004-05 assumes implementation of the enrollment caps as proposed in his Mid-Year Reduction package. The total proposed savings are $17.2 million (General Fund) for 2004-05 from these enrollment caps. Specifically, he is proposing to limit enrollment in the following Medi-Cal related programs:

- The **Breast and Cervical Cancer Treatment Services (BCCT) Program** for undocumented individuals would be capped at an enrollment level of 1,658 persons. **The Administration assumes savings of $1.8 million General Fund by establishing an average monthly "wait list" for these services of 525 individuals in 2004-05.** Under this program, individuals receive either breast cancer treatment for up to 24 months (maximum) or cervical cancer treatment for up to 18 months (maximum). No other services are provided. Eligible individuals are persons who are either underinsured or uninsured, not eligible for Medi-Cal, and have incomes below 200 percent of poverty.
- **Full-scope services for recent legal immigrants would be capped at an enrollment level of 113,139 individuals.** The Administration assumes savings of $5.6 million General Fund **by establishing an average monthly "wait list" for these services of 11,439 individuals in 2004-05**.
- **Non-emergency services for undocumented individuals which includes prenatal care and long-term care services would be capped at 794,000 individuals.** The Administration

assumes savings of $9.8 million General Fund **by establishing an average monthly "wait list" for these services of 65,900 individuals (most are assumed to need pre-natal care services)** in 2004-05.

Under this proposal, the DHS would establish statewide waiting lists on a first come first served basis. No medical necessity factors would be taken into account. As such, individuals who have more severe medical conditions or lower income, would *not* receive priority under the Administration's waiting list concept.

The Administration is also reflecting a cost of $1 million ($250,000 General Fund) for the implementation of a waiting list. This proposed cost assumes that a contractor will be hired to establish a statewide waiting list and to make related changes to the existing Medi-Cal data system. This proposed expenditure does *not* provide for any DHS staff resources that would likely be necessary for such a task or for any potential county processing changes.

In response to follow up questions regarding administration of a waiting list, it is evident that a bureaucratic nightmare would ensue. Counties would need to make changes to all of their processing systems (no funds provided). At least three separate waiting lists would need to be developed. Potentially new Medi-Cal Aid codes would have to be developed. Revised beneficiary card messages and mail notices would need to be done to know when someone is moved off of a waiting list (no funds provided).

Legislative Analyst's Office (LAO) Recommendation--Reject: The **LAO recommends for the Legislature to reject the Administration's proposed cap on these Medi-Cal programs.**

The LAO notes that in general the imposition of enrollment caps **(1)** makes programs more difficult to administer, and **(2)** makes programs more costly. For example, procedures for the establishment of waiting lists, and for dealing with disputes with program applicants over disenrollment and re-enrollment in a program, can be a complex process to administer. **They also note that the savings expected from some of the enrollment caps are fairly minor when compared to the overall program costs. They further recognize that the proposal would create inequitable gaps in coverage, create conflicts with other prior legislative decisions, and in some instances, create increased future costs for treatment services.**

Constituency Concerns: The Subcommittee is in receipt of several letters expressing concerns with the Administration's proposal. They note that pregnant women, seniors and persons with severe disabilities cannot afford to "wait" for health care. A freeze on enrollment will prevent individuals from securing preventive or critical care when they need it, aggravating otherwise simple problems, and forcing them to rely on more expensive emergency services. They contend that California will pay for more expensive services through the emergency Medi-Cal program.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1. Please explain the proposal to cap enrollment within the Medi-Cal Program.**

- **2. Please describe the process for managing a "waiting list" and the administrative costs accounted for in the budget. Would additional expenditures be needed?**

Budget Issue: Does **the Subcommittee want to adopt or reject the Administration's proposal to cap certain programs operated under the Medi-Cal Program?**

If the Subcommittee rejects the Administration's proposal, it is also recommended to delete the request for increased Administrative costs of $1 million ($250,000 General Fund).

3. Administration's Proposals Regarding Federally Qualified Health Care Centers (FQHCs) and Rural Health Care Clinics (RHCs)—Significant Change Proposed

Background—Summary of Federal Law Change and Budget Act of 2001: Prior to 2001, the state provided "cost based" reimbursement for clinics with an FQHC or RHC designation as directed by federal law. Under this "cost based" system, FQHCs and RHCs would submit cost reports, the DHS would review and audit the reports and a cost-settlement process would then determine the final Medi-Cal payment.

Through a federal law change—the Consolidated Appropriations Act of 2001—a new *"Prospective Payment System" (PPS)* was to take effect as of January 1, 2001.

Generally under a PPS, a *base* payment year would be established to pay a FQHC's/RHC's average reasonable cost. Then beginning in federal fiscal year 2002 and for each year thereafter, each FQHC/RHC would receive the *per visit base payment* increased by the percentage in the federal Medicare Economic Index (MEI) for primary care services, *and* adjusted to take into account any increase or decrease in the "scope of services".

As such, the clinic would be paid up front and, when applicable, a cost adjustment (i.e., MEI) would be provided along with any service level adjustment (i.e., scope of service changes). The purpose of this federal law was to drive increased efficiencies at the clinic level and to make program expenditures more predictable.

Under this federal law change, a state could also utilize an *"Alternative Payment Methodology"* in lieu of PPS, if certain conditions were met.

Background--California's Choice: **As discussed below, California opted to implement *both* a PPS and an Alternative Payment Method.** The state adopted the Alternative Payment Method as a compromise.

The key components to the agreed to state's process are: (1) establishment of a base payment rate (i.e., clinic selects either a PPS or alternative payment), (2) adjust future payments as appropriate using the MEI, and (3) adjust future payments as appropriate based on "scope of service" changes.

Budget Act of 2001 and Specifics of California's Agreement: Through the Budget Act of 2001 and subsequent legislation—SB 36 (Chesbro), Statutes of 2003—**California submitted a State Plan Amendment to the federal CMS for the state's PPS *and* Alternative Payment Methodology. Clinics were given the option of selecting either** the PPS method of reimbursement or the Alternative Method of reimbursement **for establishing a *base* rate per clinic visit.**

Under this agreement, the following framework was established:

- **PPS *Base* Reimbursement:** This methodology consists of taking a FQHCs/RHCs 1999 and 2000 cost reported data and calculating an average cost per visit from the two fiscal years.

- **Alternative *Base* Reimbursement:** This methodology consists of utilizing 2000 cost reported data and calculating an average cost per visit from this year alone. About **67 percent of the FQHCs/RHCs chose this base reimbursement method**.

- **Medicare Economic Index:** As contained in federal law, a FQHC's/RHC's base reimbursement (either PPS or the Alternative Method) would be adjusted by the Medicare Economic Index (MEI), effective each federal fiscal year (commencing with October 1, 2001).

- **Scope of Service Change (80/20 Method):** As contained in federal law and state law, an adjustment in the reimbursement rate is required whenever a FQHC/RHC has a "scope of service" change. **A scope of service change is defined *as an addition or deletion of a service or a change in the type, intensity, duration, or amount of services.***

  All scope of service changes must first be documented by the FQHC/RHC and approved by the DHS. Further, because of the complexity in trying to measure the appropriate dollar amount assigned to the scope of service change, a methodology was developed—the "80/20" method.

  Generally under the "80/20" method, *only* 80 percent of the cost difference from the previous fiscal year to the scope of service fiscal year is attributable to the scope of service change. The remaining 20 percent of the cost change is assumed to be normal operating increases. As such, the scope of service change is discounted from the beginning.

- **Managed Care Differential:** DHS is required to reimburse FQHCs/RHCs that provide services to Medi-Cal recipients enrolled in Managed Care Plans (Plan) an amount up to the FQHC's/RHC's PPS rate for all billable services rendered to the applicable recipients. Since the rate paid by the Plan is lower than the PPS rate, an interim rate is paid. Final reconciliation will identify the remaining differential payment that needs to be paid to the FQHCs/RHCs.

- **Medicare/Medi-Cal Crossovers:** DHS is required to reimburse FQHCs/RHCs that provide services to Medicare/Medi-Cal recipients an amount up to the FQHC's/RHC's PPS rate for all billable services rendered to the Medicare/Medi-Cal recipient. Since the rate paid by Medicare is lower than the PPS rate, an interim rate is currently paid to the FQHC/RHCs to make up for part of the difference between what Medicare pays and the PPS rate. Final reconciliation will identify the remaining differential payment that needs to be paid to facilities.

Status of the State's PPS and Alternative Payment Method—Not Yet Implemented: First, the state's PPS, including the Alternative Rate Method, that has **been under development since 2001 has not yet been fully implemented. Though clinics have effectuated scope of service changes, the DHS has not calculated the "scope of service" changes since the forms and process for calculating them were just recently completed. Federal approval of this process, as submitted in a State Plan Amendment in January 2004, is still pending.**

Therefore, the state is in arrears for paying the FQHCs/RHCs for Medi-Cal Program services provided in past years in many areas, including (1) scope of service changes, (2) MEI adjustments, (3) Managed Care adjustments, and (4) Medicare Crossover payments.

As estimated by the DHS (revised from the January budget proposal)*, these in arrears payments that the state owes the clinics is about almost $202.1 million (total funds). (See Chart below on next page.)** ***However, it is not fully clear on how the scope of service change calculation is computed since the DHS has not yet implemented the scope of service change process. Further, discussions with the clinics on how these figures were developed has not yet occurred and needs to occur.

Second as discussed below, the Administration wants to eliminate the Alternative Payment Method (which 67 percent of the clinics have been using as allowed under both state and federal law) and shift all clinics over to the PPS method. According to budget documents (as stated in the Medi-Cal Estimate), the Administration was contemplating to unilaterally proceed with this action via a State Plan Amendment to be enacted as of April 1, 2004. However, subsequent conversations have confirmed that this will not occur.

Governor's Proposed Budget and Technical Update: The Governor proposes several adjustments to the Medi-Cal reimbursement rate provided to FQHCs and RHCs through the budget. **Most notably he is proposing to eliminate the Alternative Rate Method currently used by 67 percent of the clinics. As discussed above, the DHS had contemplating proceeding with unilateral elimination of this method via a State Plan Amendment (to be enacted as of April 1, 2004) but has subsequently withheld from submittal.**

The information shown below has been revised by the DHS based upon their re-calculation of data. Further, it is likely that the May Revision will change these figures as more data becomes available.

The proposed adjustments and their *potential* fiscal effect are outlined below:

Revised Assumption	2003-04 (Revised)	2004-05 (Revised)
A. Retroactive Adjustments:	**(owed not paid)**	
• Scope of Service Changes	0	$83,522,000
• MEI Rate Adjustments	0	26,036,000
• Managed Care Adjustments	0	54,793,000
• Medicare Crossovers	0	37,696,000
SUBTOTAL (Retroactive)	**0**	**$202,047,000**
B. Ongoing Adjustments:		
• Scope of Service Change		$12,158,000
• Managed Care		0
• Medicare Crossovers		0
• Loss of Audit Recoveries **(reflects technical adjustment)**	$10,000,000	$10,000,000
SUBTOTAL (Ongoing)	**$10,000,000**	**$22,158,000**
C. Proposal to Eliminate the Alternative Payment Method	**($14,800,000) (April 1, 2004)**	**($67,200,000) Ongoing**

Significant Constituency Concerns: The Subcommittee is in receipt of letters which express significant concern regarding the lack of implementation for the scope of service changes and the proposed elimination of the Alternative Rate Method. **The proposed elimination of the Alternative Rate Method being of the most significance.**

They note that federal law sets a payment floor for FQHCs/RHCs (i.e., the minimum federal payment) and provides that states are free to adopt any equivalent or more generous payment methodology so long as a clinic consents to the alternative. **California is not currently in a position to calculate the minimum federal payment because it has not yet calculated the scope of service changes which have occurred since 2001.**

Further it is noted that the existing agreement—choice of the PPS base payment or Alternative Payment Method—was an agreed to compromise which has clearly not been enacted, and yet, the state now wants to change the deal.

Subcommittee Request and Questions: The Subcommittee has requested for the DHS to respond to the following questions:

- **1. Please provide a status update on the implementation of the scope of service change.**
- **2. Will the state be proceeding with a State Plan Amendment to eliminate the Alternative Payment Method prior to resolution of this issue via the budget process?**
- **3. What percentage of FQHCs and RHCs could be impacted through the elimination of the Alternative Payment Method?**
- **4. Why did the state originally agree to implementing an Alternative Rate Method instead of just going to the federal minimum?**
- **5. Please explain how the DHS calculated the scope of service change information when actual data is currently not yet available.**

Budget Issue: Does the Subcommittee **want to hold this issue open** until additional data is available at the May Revision and constituency groups have had an opportunity to meet with the DHS and discuss the proposed figures?

4. Medi-Cal Rates—Update on 5 Percent Reduction & Administration's Proposed Additional 10 Percent Reduction

Governor's Proposed Mid-Year Reduction and Budget: Due to the state's fiscal crisis, **the Budget Act of 2003 reduced certain Medi-Cal Program reimbursement rates by five percent effective January 1, 2004.** Certain entities were exempt from the reduction including: hospital inpatient services, hospital outpatient services, state operated facilities, Federally Qualified Health Centers/Rural Health Centers (FQHCs/RHCs), long-term care services and related items.

In his Mid-Year Reduction proposal, the Governor proposes to reduce Medi-Cal rates by *another* 10 percent, which is in addition to the five percent reduction made in the Budget Act of 2003 and to carry this reduction level forward for **a combined reduction of 15 percent**.

As noted in the table below, the two-year combined General Fund savings would be about $960 million. For providers, this would mean a loss of almost $1.9 billion in reimbursements over the course of the two-year period.

Proposed Medi-Cal Provider Rate Reduction for 2003-04 & 2004-05

Medi-Cal Category	2003-04 Assumed General Fund Savings	2004-05 Assumed General Fund Savings	Total Assumed General Fund Savings
Physicians Services	$22,787,000	$66,318,000	$89,105,000
Other Medical	16,002,000	45,063,000	61,065,000
Pharmacy	137,463,000	298,623,000	436,086,000
Medical Transportation	3,236,000	9,042,000	12,278,000
Other Services	18,718,000	53,494,000	72,212,000
Home Health	4,029,000	11,700,000	15,729,000
Dental Services	17,163,000	34,224,000	51,387,000
Early Periodic Screening Diagnosis and Treatment	811,000	2,133,000	2,944,000
Managed Care Plans	38,239,000	157,000,000	195,239,000
Family PACT	4,452,000	19,200,000	23,652,000
Total General Fund	**$262.9 million**	**$696.7 million**	**$959.6 million**
5 Percent Total (Rounded)	**($102.8 million)**	**($236.8 million)**	**($339.6 million)**
10 Percent Total (Rounded)	**($160.1 million)**	**($459.9 million)**	**($620 million)**

Update on Implementation of the 5 Percent Reduction (January 1, 2004): It should be noted that the **United States District Court recently issued a preliminary injunction stopping the implementation of the five percent reduction for the Fee-For-Service Medi-Cal reimbursement rates.** The state submitted a Motion for Reconsideration on this issue and it was denied. **The state will soon be filing an appeal with the court.** As such, further court action is pending.

However, the state can and is proceeding with a five percent reduction on Medi-Cal Managed Care Plans, as well as "state-only" (100 percent General Fund supported) programs.

According to the DHS, with respect to Managed Care Plans, their actuaries computed the actuarial equivalent of the five percent fee-for-service rate solely for the services included in the fee-for-service provider cuts (primarily these were pharmacy and physician services). Further, since each Plan has a contract period, the timing of rate decrease varies according to that contract period as follows:

Plan Name	5% Rate Decrease Applied Date	Notice of Dispute Filed?
All Two-Plan Model Plans	October 1, 2003	**Yes,** except Alameda
County Organized Plans:		
Orange (CalOPTIMA)	October 1, 2003	No
Santa Cruz (CCAH)	January 1, 2004	No
San Mateo	July 1, 2004	No
Santa Barbara	January 1, 2004	No
Solano (Partnership)	May 1, 2004	No
San Diego	July 1, 2004	No
Sacramento	January 1, 2004	No

Constituency Concerns: The Subcommittee is in receipt of several letters expressing concerns with the Governor's proposed 10 percent reduction. Patient access to needed services being a principal concern.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1.** Please provide an update on **implementation of the five percent reduction.**
- **2.** Please **explain how the additional 10 percent reduction as contained in the Governor's budget proposal was derived**?

Budget Issue: Does the **Subcommittee want to (1) adopt** the Governor's proposal to reduce Medi-Cal Rates by 10 percent, **or (2) hold open pending further information**, including further legal discussions?

5. Administration's Proposal Regarding Breast & Cervical Cancer Eligibility Processing

Background on Current Program Operations: The Budget Act of 2001 and accompanying trailer bill legislation implemented the federal Medicaid (Medi-Cal) option to provide certain health care services to individuals with breast and cervical cancer. The Breast and Cervical Cancer Treatment Program (BCCTP) was implemented January 1, 2002.

The BCCTP uses an internet-based application for *initial* eligibility determination. Under this process, a provider conducts an initial screen for eligibility and then the DHS makes the *final* eligibility determination. (This method conforms with federal law which requires a governmental entity, such as state or county government, to make final Medicaid (Medi-Cal) eligibility determinations.)

An individual can qualify for either the "state-only" portion of the program (limited-scope benefits related to the cancer treatment only), *or* full-scope Medi-Cal services. The DHS staff are required to evaluate all BCCTP recipients receiving full-scope, federally funded Medi-Cal services within a *45-day timeframe* to ensure they meet the federal criteria and are indeed eligible for federal matching funds. If the individual does not meet these criteria, they are eligible for limited-scope, cancer treatment services only (up to 18 months for breast cancer treatment and 24 months for cervical cancer treatment).

The DHS was originally provided with 13 positions for the program in 2002. The DHS eliminated one of these positions through administrative reductions.

The DHS contends that there are insufficient staff to (1) meet the 45-day period for determining eligibility, **(2)** conduct annual re-determinations, **(3)** forward applications to the counties to determine if they are eligible for any other Medi-Cal program as required by federal procedures, and **(4)** process applicants who may be eligible for up to three months of retroactive eligibility.

Governor's Proposed Budget: **The DHS currently has 12 staff dedicated to completing BCCTP eligibility determinations and redeterminations at a cost of about $1 million ($480,000 General Fund).** The DHS contends they have insufficient state staff to complete eligibility determinations on time (i.e., within the 45 day criteria). **As such**, **the Administration proposes to transfer BCCTP eligibility determinations, effective January 1, 2005, to the counties for them to administer.**

Under this proposal, the Administration would eliminate one of the 12 existing positions as of January 2005, **and all but two of the remaining positions by June 30, 2005. This position reduction would save $41,000 ($20,000 General Fund) in 2004-05, increasing to about $800,00 ($400,000 General Fund) in savings in 2005-06.**

In addition, an *increase* of $2.4 million ($1.2 million General Fund) in 2004-05 is requested to provide resources to the counties to commence with the BCCTP eligibility activities which would be shifted to them under this proposal. This funding requirement would grow

in 2005-06 to be about $5.4 million ($2.7 million General Fund). The state would continue to operate and support the internet-based application system so that signed applications for BCCTP benefits could be forwarded to counties for completion of the eligibility process.

Legislative Analyst's Office Recommendation: The LAO contends that **the Administration's proposal to shift BCCTP eligibility processing to the counties would actually result in *higher costs*, not savings.**

The total cost of the Administration's proposal, including the retention of some DHS activities, would be $3.3 million ($1.7 million General Fund) in 2004-05, and about $5.6 million ($2.8 million General Fund) in 2005-06. **Whereas if one were to just add DHS staff (i.e., an additional 11 positions to address the backlog and 45-day timeframe) in lieu of the Administration's proposal, there would be net savings of $1.850 million ($950,000 General Fund) in 2004-05, and $3.640 million ($1.840 million General Fund) in 2005-06. This is shown in the table below:**

TABLE: Summary of LAO Eligibility Comparison

Eligibility Process	2004-05 Dollars	2005-06 Dollars
Current 12 Staff	$1 million ($480,000 GF)	$1 million ($480,000 GF)
Additional Staff (11 positions)	$460 ($230,000 GF)	$920 ($460,000 GF)
LAO Option TOTAL	**$1.460 million ($710,000 GF)**	**$1.920 million ($940,000 GF)**
Governor's Proposal	**$3.310 million ($1.660 million GF)**	**$5.560 million ($2.780 million GF)**
LAO *Net* Savings	**-$1.850 million ($950,000 GF)**	**-$3.640 million ($1.840 million GF)**

Therefore, the LAO recommends to (1) delete the Administration's proposal from the budget, including the state support reduction and county administration augmentation, and **(2)** increase by 11 positions (two-year limited-term basis) and $460,000 ($230,000 General Fund) for 2004-05.

Subcommittee staff concurs with the LAO recommendation.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to respond to the following questions:

- **1. Please briefly explain the budget proposal.**
- **2. From a fiscal perspective, does the DOF concur with the LAO analysis?**

IV. 4280 Managed Risk Medical Insurance Board (MRMIB)

A. BACKGROUND

Purpose and Description of the Board

The Managed Risk Medical Insurance Board (MRMIB) administers programs, which provide health coverage through private health plans to certain groups without health insurance. **The MRMIB administers the (1) Healthy Families Program, (2) Major Risk Medical Insurance Program, and (3) Access for Infants and Mothers (AIM).**

Overall Budget of the Board

The budget proposes total expenditures of $1.156 billion ($313.6 million General Fund, $639.2 million Federal Trust Fund, $53.9 million County Health Initiative Matching Funds, and $149.7 million in other funds) for all programs administered by the Managed Risk Medical Insurance Board. Of this total amount, $7.3 million is for state operations. The budget proposes key changes to the Healthy Families Program. These are discussed below.

Summary of Expenditures (dollars in thousands)	**2003-04**	**2004-05**	**Dollar Change**	**Percent Change**
Program:				
Major Risk Medical Insurance (including state support)	$40,109	$40,002	($107)	.3
Access for Infants & Mother (including state support)	$118,709	$118,152	($557)	.5
Healthy Families Program (including state support)	$808,422	$844,307	$35,885	4.4
County Health Initiative Matching Program	$153,846	$153,846	--	--
Totals, Program Source	$1,121,086	$1,156,307	$35,221	3.1
General Fund	$303,286	$313,592	$10,306	3.4
Federal Funds	$617,860	$639,162	$21,302	3.4
County Health Initiative Matching Fund	$53,846	$53,846	--	--
Other Funds	$146,094	$149,707	$3,613	2.4
Total Funds	$1,121,086	$1,156,307	$35,221	3.1

B. ITEMS FOR DISCUSSION

1. Healthy Families Program Estimate—*ISSUES "A" to "D"*

Background—Overall on the HFP: The Healthy Families Program provides health, dental and vision coverage through managed care arrangements to uninsured children in families with incomes **up to 250 percent of the federal poverty level.**

Families pay a monthly premium and copayments as applicable. Families typically pay between $4 to $9 per child each month (with a monthly maximum of $27 per family) for the HFP. The amount paid varies according to a family's income and the health plan selected.

The benefit package is modeled after that offered to state employees. Eligibility is conducted on an annual basis. California receives an annual federal allotment of Title XXI funds (federal State-Children's Health Insurance Program) for the program for which the state must provide a 35 percent General Fund match.

Background—Overall Governor's Proposed Budget: **A total of $839.1 million ($305.5 million General Fund, $523.6 million Federal Title XXI Funds, $4.2 million Proposition 99 Funds, and $5.8 million in Reimbursements) is proposed for the HFP**, excluding state administration. **The budget proposes key changes to the Healthy Families Program, including implementation of an enrollment cap and county block grant, and development of a two-tiered benefit structure. These are discussed further below.**

ISSUE "A"—Consumer Assessment of Plans Survey

Background and Governor's Budget Proposal: The MRMIB conducts an annual survey of families enrolled in the health and dental plans participating in the HFP. The primary purpose of this survey is to assess the satisfaction and experience families have with their health and dental plans. **The Governor's budget proposes expenditures of $500,000 ($175,000 General Fund) for this purpose.**

The MRMIB has annually conducted a "Consumer Assessment of Health and Dental" survey for the past three years. They state that this survey is an effective method for meeting federal government regulations. Specifically, Section 457.495 of federal regulations require states to have a State Plan that among other things, asks states to make certain assurances regarding the quality and access to care under the program. MRMIB contends that without this survey instrument, California would not be able to fulfill this requirement.

Subcommittee Staff Recommendation: Subcommittee **staff recommends to delete the $500,000 ($175,000 General Fund) for the survey due to the state's severe fiscal situation. The Administration may be able to obtain funding from a health care foundation for this purpose, or may simply choose to inform the federal government that a survey cannot be conducted at this time due to fiscal constraints. Given that the state's program has not**

changed significantly over the past year, the federal CMS may even allow California to use its past-year survey.

Given the option of reducing services to children under the HFP or reducing administrative components, it seems only reasonable to reduce the administrative components.

Subcommittee Request: The Subcommittee has requested the MRMIB to briefly respond to the following question:

- **1.** Is it *necessary* for the state to conduct a survey for 2004-05 ? If so, specifically why?

Budget Issue: Does the Subcommittee **want to adopt the Subcommittee staff recommendation to reduce administrative components of the program**, in lieu of making health care service reductions to children?

ISSUE "B"—Governor's Proposed Cap on Enrollment *(See Hand Out)*

Governor's Mid-Year Reduction Package and Proposed Budget: As part of his Mid-Year Reduction package, **the Governor proposed to cap enrollment in the HFP as of January 1, 2004, for a total enrollment of 732,344 children, with 22,000 less children being served by the end of June 30, 2004 (i.e., end of the current-fiscal year). The proposal requires statutory change before implementation can occur.** Presently, no action has been taken on this issue, though other Mid-Year Reductions (i.e., changes to the 2003-04 current year budget) have occurred.

Under this proposal, the MRMIB would establish statewide waiting lists on a first come first served basis. No medical necessity factors would be taken into account. As such, individuals who have more severe medical conditions or lower income, would *not* receive priority under the Administration's waiting list concept.

The Governor's proposed budget for 2004-05 assumes implementation of the enrollment caps as proposed in his Mid-Year Reduction package. The proposed savings are $86.3 million ($ 31.5 million General Fund) for 2004-05 by capping the program at an enrollment level of 737,000 children with 114,000 less children being served by the end of June 30, 2005 (i.e., end of the 2004-05 year). It should be noted that the enrollment level of 737,000 children reflects the capped level coupled with an enrollment of 4,960 infants born to women enrolled in the Access for Infants and Mothers (AIM) Program.

The MRMIB is also **seeking an increase of $1 million ($ 350,000 General Fund) in new administrative costs associated with the HFP enrollment cap. The MRMIB states that these funds would be needed for the following activities:**

- $500,000 for system and process modifications for the Administrative Vendor.
- $400,000 for telephone costs due to anticipated call volume.
- $50,000 for producing and inserting errata sheets into the existing HFP handbooks.
- $50,000 for producing modifications to open enrollment materials and annual enrollment materials

Loss of Federal State-Childrens Health Insurance Program (S-CHIP) Funds: Since the inception of the HFP, California has not fully utilized its federal allotment of S-CHIP funds. To date, **the state has reverted $1.1 billion in unspent funds back to the federal government**, which was redistributed to other states that were able to expend their allotment within the specified time period. The LAO notes as of May 2003, California had about $1.9 billion in unspent S-CHIP funds remaining.

The Governor's enrollment cap proposal will reduce federal funds by $55 million.

Legislative Analyst's Office Recommendation: **The LAO recommends for the Legislature to reject the Administration's proposed cap on the HFP**, including the legal immigrant block grant (discussed below). **The LAO notes that in general the imposition of enrollment caps (1) makes programs more difficult to administer**, and (2) makes programs more costly. **For example, procedures for the establishment of waiting lists, and for dealing with disputes with program applicants over disenrollment and re-enrollment in a program, can be a complex process to administer.**

The LAO recognizes that the proposal would create inequitable gaps in coverage because no medical necessity criteria would be used for establishing the "wait list", and children who entered the program prior to January 1, 2004 (or other identified timeframe) would be treated differently than those who came after an implementation date.

Another equity issue pertains to how this cap would be implemented in the context of other publicly supported health programs. For example, while enrollment would be capped for children in families under 250 percent of poverty in the HFP, the Governor's budget plan proposes to continue implementation of the County Health Initiative Matching Fund (CHIM) for counties to support their county health initiatives to provide coverage to children in families with incomes between 250 percent and 300 percent of poverty.

The LAO also notes that based on past enrollment trends, the potential waiting period for coverage will grow over time, reaching as long as six months by the end of 2004-05 (budget year). Their analysis indicates that the waiting list would grow to about 280,000 children by the end of 2005-06 and that the last child to enroll before June 30, 2006 would not receive coverage until June 2007.

Constituency Concerns: The Subcommittee is in receipt of several letters expressing significant concerns with the Administration's proposal.

Subcommittee Staff Comment and Recommendation: **Subcommittee staff concurs with the LAO recommendation. Conceivably, children placed on a "waiting list" would need to seek health care, dental and vision services from other sources, including county indigent programs, emergency room care, other available state programs, and charity care (as available), or become sicker and more medically involved.**

Without question, prevention and early remediation are the most cost-beneficial approaches to overall health care, particularly children's health. Unhealthy children will have school adjustment problems and difficulty in learning and progressing through their education. **Low-income families are paying premiums and copayments to have their children participate in this program because other health care options are not available to them.** Limiting this option for families could be catastrophic.

However, it is also suggested for the Subcommittee to develop options for program efficiencies, cost containment, fund shifting (to federal versus state General Fund), and related items. ***These potential options could then be discussed at subsequent hearings.***

Subcommittee Request and Questions: The Subcommittee requests for the MRMIB to respond to the following questions:

- **1.** Please **briefly explain the Governor's enrollment cap** for the HFP.
- **2. What would the waiting list time be for an applicant before they actually received health care coverage? Could it be longer than six months?**
- **3. Is it likely that California will be reverting unspent funds back to the federal government this year? If so, about how much?**

Budget Issue: Does the **Subcommittee want to adopt or reject the Administration's proposal to cap enrollment into the HFP?**

ISSUE "C"—Governor's Proposal to Block Grant HFP to Counties

Governor's Proposed Budget: The Governor proposes to restructure and **consolidate *certain* state-only funded programs that provide health and human services to legal immigrants, including the HFP, CalWORKs, the California Food Assistance Program, and the Cash Assistance Program for Immigrants.**

Under his proposal, these programs would have their enrollments capped and then funding would be shifted to the counties in the form of a block grant. **Although funding for legal immigrants remains in the HFP budget for 2004-05, the budget reflects savings of $848,721 (General Fund) from this action, *supposedly due to anticipated administrative efficiencies* resulting from this proposal. The "savings" figure represents a five percent reduction.**

Legislative Analyst's Office Recommendation: In her Analysis, **the Legislative Analyst recommends for the Legislature to reject this proposal because the programs proposed for transfer to the counties are not well-suited for local control.**

Subcommittee Staff Comment and Recommendation: Subcommittee **staff concurs with the LAO recommendation.** The Healthy Families Program **with a medical risk pool of over 700,000 children will be able to achieve significantly more economies of scale, not to mention better health care plan rates, than individual counties trying to negotiate health plan packages for a much smaller population.**

Further, the Administration has yet to articulate specifically how the $848,721 (General Fund) is savings is to be achieved by the counties. The Administration's figure is simply a reduction.

Therefore, it is recommended for the Subcommittee to restore the $848,721 (General Fund) and to eliminate the HFP from the county block grant discussion. The other programs related to this proposal (such as CalWORKS, and Food Stamps will be discussed when the Department of Social Services is heard.)

Subcommittee Request and Questions: The Subcommittee has requested the MRMIB to respond to the following questions:

- **1.** Please briefly explain the Administration's proposal to include a portion of the Healthy Families Program in a block grant to the counties.
- **2.** Exactly how would the "anticipated efficiencies" be achieved by the counties?

Budget Issue: Does the Subcommittee **want to adopt or reject the Administration's proposal to shift a portion of the Healthy Families Program to the counties?**

ISSUE "D"—Governor's Proposed Two-Tiered Benefit Structure

Governor's Proposed Budget: The **Governor proposes to implement a two-tiered benefit package commencing in *2005-06***. Under this proposal, enrolled children with family incomes between 201 percent and 250 percent of poverty would be offered a choice of either a basic benefit package (excludes dental and vision coverage) or the standard HFP package. Enrollment in the standard HFP package would require higher monthly premiums and possibly more copayments.

The budget assumes increased costs of $750,000 ($263,000 General Fund) to modify the HFP administrative system and related functions in 2004-05. The Administration has not yet provided details as to what level of savings may be anticipated in 2005-06 for this proposal, or what levels of monthly premiums or copayments would be assumed.

Subcommittee Staff Comment and Recommendation—Policy Legislation: This proposal represents substantive policy change and does not have budgetary implications until 2005-06. **As such the Administration has been informed by the Senate through the DOF to introduce this proposal through the legislative policy process.** The requested $750,000 ($263,000 General Fund) to modify the HFP administrative system should be included in this legislation since it is unknown at this time what the final components of the legislation will be, as well as its eventual outcome. As such, the bill can carry the appropriation.

It is therefore recommended to delete the $750,000 ($263,000 General Fund) from the HFP budget and to delete, *without prejudice*, any proposed trailer bill language regarding this issue.

Subcommittee Request and Questions: The Subcommittee has requested for the MRMIB to respond to the following questions:

- **1. Please briefly explain the proposal.**

2. Access for Infants and Mothers (AIM) Program Reserve—LAO Recommendation

Background: The **Access for Infants and Mothers (AIM) Program provides health insurance coverage to women during pregnancy and up to 60 days postpartum, and covers their infants up to two years of age. Eligibility is limited to families with incomes from 200 to 300 percent of the poverty level. Eligible women select coverage from one of the nine participating health plans. Subscribers pay premiums equal to 2 percent of the family's annual income plus $100 for the infant's second year of coverage.**

Beginning July 1, 2004, infants in families between 200 and 250 percent of poverty are funded through the Healthy Families Program using General Fund and federal Title XXI funds (35 percent/65 percent). AIM infants in families between 250 and 300 percent of poverty (above the Healthy Families Program income threshold) are funded with 100 percent state funds (General

Fund and Proposition 99 Funds). This fiscal arrangement enables the state to more effectively utilize available federal funds and state funds.

A total of $118.1 million ($99.5 million Perinatal Insurance Fund—receives Proposition 99 Funds--, $6.5 million General Fund, $12.1 million federal funds) is proposed for AIM. A total of 8,783 women and 160,880 infants are expected to enroll in AIM in 2004-05.

No significant policy or budget adjustments are being proposed by the Administration at this time.

Legislative Analyst Office Recommendation—AIM Reserve Funds Available: In her Analysis, the **Legislative Analyst recommends for the Legislature to repeal the statutory requirement that the AIM Program maintain a reserve in the Perinatal Insurance Fund, thereby achieving about $1 million in Proposition 99 Funds. (These funds can be used to backfill for General Fund support in certain program areas.)**

The LAO's analysis indicates that there is no need for a separate and special reserve fund for AIM. **In the event that AIM Program expenditures exceed the 2004-05 budgeted amount, an alternative source of funding is available to fund unanticipated expenses. Specifically, a separate reserve is maintained for state programs supported through Proposition 99. The Governor's budget for 2004-05 sets aside about $10.7 million for the Proposition 99 reserve.**

Therefore, in light of the fiscal difficulties and the availability of the set aside reserve of $10.7 million, the special reserve for AIM is not needed.

Subcommittee Staff Comment: Subcommittee staff **concurs with the LAO recommendation to delete the AIM reserve amount of $1 million (Perinatal Insurance Fund) from the proposed budget and to add this amount to the existing Proposition 99 Fund reserve. The reserve would therefore increase to be about $11.7 million.**

(Further discussions regarding this reserve, as well as other Proposition 99 Funded programs will be conducted at subsequent Subcommittee hearings.)

Subcommittee Request and Questions: The Subcommittee has requested the MRMIB to respond to the following questions:

- **1.** Please respond to the LAO recommendation.

LAST PAGE OF THE AGENDA